

CHALENG 2004 Survey: VA Central Texas HCS (VAMC Marlin - 674A5, VAMC Temple - 674 and VAMC Waco - 674A4), Austin

VISN 17

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1040

2. Point-in-time estimate of Veterans who are Chronically Homeless: 327

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; <http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf>

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

1040 (point-in-time estimate of homeless veterans in service area)
X 37% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 84%** (percentage of veterans served who had a mental health or substance abuse disorder) = **327** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	744	0
Transitional Housing Beds	135	50
Permanent Housing Beds	6	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Secure a facility that will provide emergency housing for chronically homeless in Waco.
Transitional living facility	Secure a facility that will provide transitional housing for chronically homeless.
Long-term, permanent housing	Waco: Create permanent housing choices for chronic homeless. Develop permanent supportive housing facilities. Austin: Application made through HUD to build 20 units for chronically mentally ill. Housing coalition formed to locate other resources for housing.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 31 Non-VA staff Participants: 94%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.03	48%	2.25	1
2	Dental care	2.14	0%	2.34	2
3	Eye care	2.29	0%	2.65	5
4	Glasses	2.29	4%	2.67	6
5	Help managing money	2.34	9%	2.71	7
6	Guardianship (financial)	2.41	13%	2.76	9
7	Legal assistance	2.45	0%	2.61	4
8	Child care	2.46	0%	2.39	3
9	Detoxification from substances	2.52	13%	3.11	22
10	Help with transportation	2.54	0%	2.82	11
11	Treatment for substance abuse	2.58	13%	3.30	28
12	Halfway house or transitional living facility	2.61	17%	2.76	8
13	Drop-in center or day program	2.61	4%	2.77	10
14	Education	2.61	4%	2.88	13
15	Help with finding a job or getting employment	2.64	0%	3.00	17
16	Job training	2.66	9%	2.88	14
17	Treatment for dual diagnosis	2.69	0%	3.01	18
18	Help with medication	2.69	0%	3.18	24
19	Discharge upgrade	2.69	4%	2.90	15
20	Services for emotional or psychiatric problems	2.7	9%	3.20	25
21	Emergency (immediate) shelter	2.74	13%	3.04	20
22	Family counseling	2.75	0%	2.85	12
23	Help getting needed documents or identification	2.75	4%	3.16	23
24	Women's health care	2.79	4%	3.09	21
25	SSI/SSD process	2.82	13%	3.02	19
26	TB treatment	2.86	0%	3.45	33
27	Welfare payments	2.96	0%	2.97	16
28	Medical services	3.03	4%	3.55	34
29	Hepatitis C testing	3.04	0%	3.41	32
30	Personal hygiene (shower, haircut, etc.)	3.06	0%	3.21	26
31	AIDS/HIV testing/counseling	3.07	0%	3.38	30
32	TB testing	3.07	0%	3.58	36
33	Spiritual	3.11	0%	3.30	27
34	Clothing	3.19	0%	3.40	31
35	VA disability/pension	3.19	4%	3.33	29
36	Food	3.35	9%	3.56	35

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.72	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.41	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.11	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.03	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.07	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.89	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.6	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.42	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale 1 = None , no steps taken to initiate implementation of the strategy. 2 = Low , in planning and/or initial minor steps taken. 3 = Moderate , significant steps taken but full implementation not achieved. 4 = High , strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.65	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.35	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.39	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.26	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.7	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.57	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.64	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.09	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.82	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.95	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.91	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.83	1.84

CHALENG 2004 Survey: VA North Texas HCS (VAMC Bonham - 549A4 and VAMC Dallas - 549)

VISN 17

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 5000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 998

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; <http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf>

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

5000 (point-in-time estimate of homeless veterans in service area)
X 22% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) = **998** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2000	120
Transitional Housing Beds	210	70
Permanent Housing Beds	430	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 25

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Entered into partnership with local nonprofit housing agency for \$1.5 million vet-specific Shelter Plus Care Grant under HUD SuperNOFA. Would provide 30 apartments for unaccompanied veterans and 10 apartments for families.
Transitional living facility	Continue to develop partnership with community half-way house. Anticipate having up to 50 beds set aside for veterans in a 90-day, dual diagnosis transitional treatment program.
Child Care	Working with two homeless child care providers to assist homeless veterans with minor dependents.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 45 Non-VA staff Participants: 74%
Homeless/Formerly Homeless: 36%

1. Needs Ranking (1=Need Unmet 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.32	46%	2.25	1
2	Halfway house or transitional living facility	2.51	16%	2.76	8
3	Dental care	2.53	3%	2.34	2
4	Child care	2.59	0%	2.39	3
5	Legal assistance	2.63	5%	2.61	4
6	Guardianship (financial)	2.71	0%	2.76	9
7	SSI/SSD process	2.74	0%	3.02	19
8	Discharge upgrade	2.74	0%	2.90	15
9	Family counseling	2.8	8%	2.85	12
10	Eye care	2.8	0%	2.65	5
11	Welfare payments	2.81	0%	2.97	16
12	Glasses	2.88	0%	2.67	6
13	Help with finding a job or getting employment	2.88	16%	3.00	17
14	Help managing money	2.89	11%	2.71	7
15	Detoxification from substances	2.95	16%	3.11	22
16	Education	3	13%	2.88	13
17	Help with transportation	3.05	5%	2.82	11
18	Treatment for dual diagnosis	3.1	5%	3.01	18
19	Job training	3.1	3%	2.88	14
20	Treatment for substance abuse	3.15	3%	3.30	28
21	Women's health care	3.18	5%	3.09	21
22	Services for emotional or psychiatric problems	3.22	11%	3.20	25
23	VA disability/pension	3.24	5%	3.33	29
24	Spiritual	3.24	5%	3.30	27
25	Emergency (immediate) shelter	3.33	8%	3.04	20
26	Help getting needed documents or identification	3.33	0%	3.16	23
27	Help with medication	3.34	3%	3.18	24
28	Drop-in center or day program	3.39	0%	2.77	10
29	Clothing	3.43	5%	3.40	31
30	Personal hygiene (shower, haircut, etc.)	3.49	0%	3.21	26
31	Food	3.5	3%	3.56	35
32	Hepatitis C testing	3.58	0%	3.41	32
33	Medical services	3.66	5%	3.55	34
34	TB treatment	3.7	0%	3.45	33
35	AIDS/HIV testing/counseling	3.71	0%	3.38	30
36	TB testing	3.78	0%	3.58	36

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.66	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.43	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.93	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.93	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.72	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.68	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.42	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale 1 = None , no steps taken to initiate implementation of the strategy. 2 = Low , in planning and/or initial minor steps taken. 3 = Moderate , significant steps taken but full implementation not achieved. 4 = High , strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.24	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.25	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.4	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.89	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.97	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.36	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.66	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.91	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.92	1.84

CHALENG 2004 Survey: VA South Texas Veterans HCS (VA OPC Corpus Christi, TX - 671BZ)

VISN 17

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 784

2. Point-in-time estimate of Veterans who are Chronically Homeless: 321

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; <http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf>

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

784 (point-in-time estimate of homeless veterans in service area)
X 42% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 97%** (percentage of veterans served who had a mental health or substance abuse disorder) = **321** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	456	393
Transitional Housing Beds	110	701
Permanent Housing Beds	90	450

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Other	Need: Service coordination. Homeless coalition getting Homeless Management Information System.
Dental Care	Dental care is being provided for veterans in homeless programs after the 60-day minimum stay.
Treatment for substance abuse	Charlie's Place is providing detox more promptly. Treatment to be provided in community.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 19 Non-VA staff Participants: 84%
Homeless/Formely Homeless: 11%

1. Needs Ranking (1=Need Unmet 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.93	8%	2.25	1
2	Halfway house or transitional living facility	2.07	23%	2.76	8
3	Detoxification from substances	2.14	8%	3.11	22
4	Emergency (immediate) shelter	2.31	15%	3.04	20
5	Dental care	2.36	0%	2.34	2
6	Treatment for dual diagnosis	2.43	8%	3.01	18
7	Treatment for substance abuse	2.5	8%	3.30	28
8	Guardianship (financial)	2.55	8%	2.76	9
9	Glasses	2.57	8%	2.67	6
10	Eye care	2.64	0%	2.65	5
11	Services for emotional or psychiatric problems	2.71	8%	3.20	25
12	Help with transportation	2.77	23%	2.82	11
13	Family counseling	2.79	0%	2.85	12
14	Child care	2.82	0%	2.39	3
15	Legal assistance	2.82	8%	2.61	4
16	Women's health care	2.83	0%	3.09	21
17	SSI/SSD process	2.83	8%	3.02	19
18	Personal hygiene (shower, haircut, etc.)	2.88	8%	3.21	26
19	Help managing money	2.91	0%	2.71	7
20	Job training	2.92	15%	2.88	14
21	Education	2.92	0%	2.88	13
22	AIDS/HIV testing/counseling	3	0%	3.38	30
23	Welfare payments	3	0%	2.97	16
24	Drop-in center or day program	3.07	0%	2.77	10
25	Help getting needed documents or identification	3.08	0%	3.16	23
26	Discharge upgrade	3.09	0%	2.90	15
27	Medical services	3.13	0%	3.55	34
28	Help with medication	3.14	0%	3.18	24
29	Help with finding a job or getting employment	3.15	31%	3.00	17
30	Hepatitis C testing	3.36	0%	3.41	32
31	VA disability/pension	3.46	7%	3.33	29
32	TB testing	3.47	0%	3.58	36
33	TB treatment	3.5	0%	3.45	33
34	Clothing	3.53	8%	3.40	31
35	Food	3.56	8%	3.56	35
36	Spiritual	3.75	8%	3.30	27

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.06	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.19	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.13	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.63	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.88	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.33	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.53	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.57	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale 1 = None , no steps taken to initiate implementation of the strategy. 2 = Low , in planning and/or initial minor steps taken. 3 = Moderate , significant steps taken but full implementation not achieved. 4 = High , strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.38	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.64	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.18	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.83	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.42	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments - Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.45	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.08	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding - Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.64	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.82	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

CHALENG 2004 Survey: VA South Texas Veterans HCS (VAMC Kerrville - 671A4 and VAH San Antonio - 671).

VISN 17

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1510

2. Point-in-time estimate of Veterans who are Chronically Homeless: 618

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; <http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf>

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

1510 (point-in-time estimate of homeless veterans in service area)
X 42% (percentage of veterans served who indicate being homeless for a year or more at intake) **X 97%** (percentage of veterans served who had a mental health or substance abuse disorder) = **618** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1194	10
Transitional Housing Beds	792	100
Permanent Housing Beds	40	240

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 20

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	The GI-Forum VA Grant and Per Diem Program is scheduled to open in December 2004. This will provide 80 transitional beds for homeless veterans.
Long-term, permanent housing	The GI Forum is scheduled to open 30 SRO units in FY 2005. Most of these beds will be used to house formerly homeless veterans.
Treatment for substance abuse	A VA PRRT is being developed to house up to 8 veterans who are awaiting placement in a VA-SARRTP program or a domiciliary program. This will help alleviate the problem with these veterans having to wait on the streets or in shelters until they are placed in treatment.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 30 Non-VA staff Participants: 70%
Homeless/Formely Homeless: 3%

1. Needs Ranking (1=Need Unmet 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.41	4%	2.39	3
2	Legal assistance	2.52	4%	2.61	4
3	Long-term, permanent housing	2.54	26%	2.25	1
4	Help with transportation	2.59	0%	2.82	11
5	Help managing money	2.66	0%	2.71	7
6	Guardianship (financial)	2.71	0%	2.76	9
7	Dental care	2.72	4%	2.34	2
8	Detoxification from substances	2.79	26%	3.11	22
9	Drop-in center or day program	2.83	4%	2.77	10
10	Treatment for dual diagnosis	2.93	15%	3.01	18
11	Glasses	2.96	0%	2.67	6
12	Education	2.96	4%	2.88	13
13	Discharge upgrade	2.96	0%	2.90	15
14	Eye care	2.97	0%	2.65	5
15	Halfway house or transitional living facility	3.03	22%	2.76	8
16	Women's health care	3.03	0%	3.09	21
17	Job training	3.03	7%	2.88	14
18	Emergency (immediate) shelter	3.07	15%	3.04	20
19	Services for emotional or psychiatric problems	3.07	22%	3.20	25
20	SSI/SSD process	3.07	0%	3.02	19
21	Help with finding a job or getting employment	3.07	7%	3.00	17
22	Welfare payments	3.1	4%	2.97	16
23	Help with medication	3.11	0%	3.18	24
24	Family counseling	3.14	4%	2.85	12
25	Treatment for substance abuse	3.17	15%	3.30	28
26	Help getting needed documents or identification	3.28	0%	3.16	23
27	Hepatitis C testing	3.29	0%	3.41	32
28	AIDS/HIV testing/counseling	3.38	4%	3.38	30
29	Personal hygiene (shower, haircut, etc.)	3.39	0%	3.21	26
30	Spiritual	3.57	7%	3.30	27
31	TB testing	3.59	0%	3.58	36
32	Clothing	3.66	0%	3.40	31
33	Medical services	3.66	0%	3.55	34
34	VA disability/pension	3.66	4%	3.33	29
35	TB treatment	3.69	0%	3.45	33
36	Food	3.86	4%	3.56	35

* % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	VHA
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.66	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.22	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.11	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.26	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.11	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.38	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale 1 = None , no steps taken to initiate implementation of the strategy. 2 = Low , in planning and/or initial minor steps taken. 3 = Moderate , significant steps taken but full implementation not achieved. 4 = High , strategy fully implemented.	Site	VHA
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.7	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.35	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.43	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.65	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.8	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.6	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.6	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.6	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.65	1.84